PORT WASHINGTON-SAUKVILLE SCHOOL DISTRICT

We educate all children to reach their greatest potential.

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Release Form for Self Carry of Medications

Date: ________________________ School: ____

__________________________________ has been instructed in the proper use of the
(Student's Full Name)

following prescribed medication: ____.
(Name of Medication(s))

We, __________________________________ and __________________________________
(Medical Provider) (Parent/Legal Guardian)

request that _________________________________ be permitted to carry this medication on
(Student's Full Name)

his/her person, and to take it as he/she has been instructed, as we consider him/her able to accept such responsibility. **He/she has been instructed in and understands the purpose and potential side effects of his/her medication(s).**

We, the undersigned professional medical provider and parent/legal guardian absolve the Port Washington Saukville School District and its employees, agents and officers of any responsibility in safeguarding this child's medication(s).

___________________________ _________ ___________________________ _________
(Medical Provider's Signature) (Date) (Parent/Legal Guardian Signature) (Date)